DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11097 (Rev. 06/06)

STATE OF WISCONSIN

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STIMULANTS AND RELATED AGENTS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, HCF 11097A.

Pharmacy providers are required to have a completed PA/PDL for Stimulants and Related Agents signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name and Strength
5. Date Prescription Written
6. Directions for Use
7. Diagnosis — Primary Code and / or Description (The diagnosis code must be one of the stimulant-approved diagnosis codes.*)
8. Name — Prescriber
9. Drug Enforcement Agency Number
10. Address — Prescriber (Street, City, State, Zip Code)
11. Telephone Number — Prescriber
12. **SIGNATURE** — Prescriber
13. Date Signed
14. Has the recipient taken a non-preferred drug for more than 30 days outside the Wisconsin Medicaid system and had a measurable, therapeutic response? ❑ Yes ❑ No

SECTION IIIA — CLINICAL INFORMATION FOR STRATTERA

15. Does the recipient have a diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD) **and** Tourette's Syndrome or a history of tics? ❑ Yes ❑ No
16. Does the recipient have a diagnosis of ADD or ADHD **and** obsessive compulsive disorder? ❑ Yes ❑ No
17. Does the recipient have a medical history of substance abuse or misuse? ❑ Yes ❑ No
    If yes, explain in the space provided.
18. Does the recipient have a serious risk of diversion? ❑ Yes ❑ No
    If yes, explain in the space provided.
19. Has the recipient tried and failed or had an adverse reaction to a preferred stimulant? ❑ Yes ❑ No
    If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced.

Continued

SECTION IIIB — CLINICAL INFORMATION FOR PROVIGIL

For PA approval, providers must check "yes" for Element 20 **or** check "yes" for Elements 21, 22, and 23.

20. Does the recipient have a diagnosis of narcolepsy or idiopathic hypersomnolence, obstructive sleep apnea / hypopnea syndrome (OSAHS), or shift work sleep disorder (SWSD)?**?** If yes, circle the diagnosis listed. ❑ Yes ❑ No

21. Does the recipient have a diagnosis of ADD or ADHD? ❑ Yes ❑ No

22. Has the recipient tried and failed or had an adverse reaction to **two** preferred stimulants? If yes, indicate in the space provided the failed drugs or the adverse reaction experienced. ❑ Yes ❑ No

23. Does the prescriber have peer-reviewed medical literature to support the proven efficacy of the requested use of the drug for ADD or ADHD? If yes, indicate in the space provided the medical literature references. ❑ Yes ❑ No

SECTION IIIC — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS AND RELATED AGENTS

24. Does the recipient have a diagnosis of ADD or ADHD? ❑ Yes ❑ No

25. Has the recipient tried and failed or had an adverse reaction to a preferred stimulant? If yes, indicate in the space provided the failed drug(s) or the adverse reaction experienced. ❑ Yes ❑ No

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

26. National Drug Code (11 digits)

27. Days' Supply Requested (up to 365 days)

28. Wisconsin Medicaid Provider Number (Eight digits)

29. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

30. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

31. Assigned PA Number (Seven digits)

32. Grant Date

33. Expiration Date

34. Number of Days Approved

Continued

SECTION V — ADDITIONAL INFORMATION

35. Indicate any additional information in the space below. Submit additional information on a separate sheet if necessary.

*The following are stimulant-approved diagnosis codes for the drugs listed.

Strattera (atomoxetine HCl) Cylert (pemoline) Desoxyn (methamphetamine)	
31400	Attention Deficit Disorder without mention of hyperactivity
31401	Attention Deficit Disorder with hyperactivity
314-3140	Hyperkinetic syndrome of childhood — Attention Deficit Disorder

Provigil (modafinil)	
31400	Attention Deficit Disorder without mention of hyperactivity
31401	Attention Deficit Disorder with hyperactivity
314-3140	Hyperkinetic syndrome of childhood — Attention Deficit Disorder
34700	Narcolepsy, without cataplexy
34701	Narcolepsy, with cataplexy
78057	Other and unspecified sleep apnea